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Manulife Financial

MEDICAL CLAIM FORM

COMPANY NAME _____

POLICY NUMBER _____ DIVISION NUMBER _____ CERTIFICATE NUMBER _____

EMPLOYEE'S NAME _____ _____
SURNAME FIRST NAME

PATIENT'S NAME _____ _____ _____
SURNAME FIRST NAME RELATIONSHIP TO EMPLOYEE

ADDRESS _____ _____ _____ _____
STREET CITY PROVINCE POSTAL CODE

(A) YOUR PHYSICIAN MUST COMPLETE THIS SECTION IF CLAIMING FOR HOSPITAL OR PHYSICIAN SERVICES. USE EXACT WORDING OF SCHEDULE OF FEES.

SERVICE DATE	SERVICE CODE	DIAGNOSTIC CODE	OHIP/ONTARIO MEDICAL ASSOC. FEE SUBMITTED

YOUR TOTAL CHARGES FOR THESE VISITS $ _____

I DECLARE THAT THE ABOVE IS A CORRECT STATEMENT OF SERVICES PERSONALLY RENDERED BY ME.

PHYSICIAN'S NAME _____ ADDRESS _____

PHYSICIAN'S SIGNATURE _____ TELEPHONE NUMBER _____

CHEQUE SHOULD BE MADE PAYABLE TO ☐ EMPLOYEE OR ☐ OTHER (INDICATE BELOW)

NAME _____

ADDRESS _____

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I AUTHORIZE THE RELEASE TO MANULIFE FINANCIAL AND ITS REINSURERS ALL INFORMATION REQUESTED WITH RESPECT TO MY CLAIM. A COPY OR PHOTOCOPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL.

DATE: _____ CLAIMANT'S SIGNATURE: _____